V. Goals and Objectives for Virginia's HIV Services Plan, 2022-2026

NHAS GOAL #1: PREVENT NEW HIV INFECTIONS			
Objective 1.1: By December 31, 2026, increase health communications activities to prevent HIV and improve HIV-related health outcomes among priority populations.			
Key Partners: DDP, LHD, Pharmacies, Clinical sites, CBOs, FQHCs			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Conduct health communications activities/campaigns to promote HIV testing among young people (20-34), Latinos, Black MSM, and Heterosexual males, ensuring community engagement in the development of messaging and channels. *(Diagnose, Prevent)*	TBD	Increase in use of test site locators; Increase in HIV testing among priority populations. **(NHSP Indicator#1)**	campaign metrics, DDP hotline call log, Evaluation Web, Provide
Strategy B: Conduct health communications activities/campaigns to promote PrEP among MSM of all races and ethnicities, Black Women, Transgender women and non-gender conforming (NGC) individuals, ensuring community engagement in the development of messaging and channels. *(Diagnose, Prevent)*	TBD	Measure click through rates and ad activities by location; **(NHSP Indicator#1, 2, 3, 7)**	campaign metrics, Provide
Strategy C: Conduct health communications activities/campaigns that address HIV stigma and U=U among the general population, as well as rural areas. *(Diagnose, Treat, Prevent)*	TBD	**(NHSP Indicator #7)**	campaign metrics, surveys; eHARS; Caremarkers database

Objective 1.2: By December 31, 2026, increase knowledge of HIV status among people in Virginia			
Key Partners: DDP, LHD, Pharmacies, Clinical sites, CBOs, FQHCs, Correctional Facilities			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Expand HIV testing in both clinical and non-clinical settings, home testing, pharmacies, and comprehensive harm reduction (CHR) sites, continuing the "No Wrong Door" approach. *(Diagnose, Prevent)*	CDC, HRSA, ARPA, State	Increase in number of HIV tests over 2019 (pre-COVID-19) testing levels. **(NHSP Indicator#1, 2, 3)**	Evaluation Web/Provide
Strategy B: By January 1, 2024, merge the Community HIV Testing (CHT) and Status Neutral Service Navigation (SNSN) grant programs to improve linkage to HIV care, PrEP and support services. *(Diagnose, Prevent, Treat)*	CDC	Reduced time for linkage to care; increased linkage for PrEP and support services. **(NHSP Indicator# 2, 3, 5, 6)**	Evaluation Web
Strategy C: Increase the capacity of HIV test sites to conduct STI and hepatitis testing and to perform blood draws for conventional testing *(Diagnose, Prevent, Treat)*	CDC, State	Increase in STI, hepatitis and conventional HIV testing. **(NHSP Indicator# 1, 2, 3)**	Labcorp reporting, Evaluation Web, contractor reports, REDCap
Strategy D: Increase HIV testing among young people (20-34), Black MSM, and PWID in the Norfolk TGA. *(Diagnose, Prevent)*	CDC/HRSA RW Part A	Increase in HIV tests among priority populations. Reduction in late diagnoses. **(NHSP Indicator# 1, 2, 3, 5, 6b, 6g, 6h)**	Evaluation Web. Provide, CAREWare
Strategy E: Ensure third trimester HIV testing in at least 85% of pregnant persons diagnosed with HIV with a baseline of 80% in 2021 and refer them to high risk OB GYN care in the RWHAP cross parts care system (*Diagnose, Prevent)*	CDC	Reduction in HIV perinatal transmission. **(NHSP Indicator#1, 2, 3, 5, 6e)**	eHARS
Strategy F: Increase viral suppression rate at third trimester in pregnant persons diagnosed with HIV to 85% with a baseline of 80% in 2021 (*Treat, Prevent)*	CDC	Reduction in HIV perinatal transmission. **(NHSP Indicator#1, 2, 3, 5, 6e)**	eHARS
Strategy G: Educate and counsel 95% of people diagnosed with syphilis about HIV risk and provide referrals to PrEP services. *(Prevent)*	CDC	# diagnosed with syphilis/ with referral to PrEP. **(NHSP Indicator#1, 2, 3, 5)**	VEDSS, Provide

Strategy H: Beginning January 1, 2024, implement DIS interviews and referrals for patients with STIs who are 1.) co-infected with HIV and are not in care or have high viral loads, and 2.) those with rectal GC. *(Diagnose, Prevent, Respond, Treat)*	CDC HIV Prevention CDC STI, HRSA	# diagnosed w/ chlamydia or gonorrhea and co-infected with HIV (not in care or detectable VL) who are interviewed and linked to care; # diagnosed w/ rectal GC who are interviewed and referred to PrEP services. **(NHSP Indicator# 2, 3, 5)**	eHARS, VEDSS

Objective 2.1: By December 31, 2026, link people to care immediately after diagnosis and provide low-barrier access to HIV treatment			
Key Partners: DDP, LHD, clinical and non-clinical test sites, Ryan White Cross-Parts, FQHCs, Department of Corrections. local and regional jails			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Increase the number of HIV service providers that participate in Rapid Start. *(Diagnose, Treat, Prevent)*	HRSA, HRSA cross-parts funding, providers program income, Medicaid	increase # of clients served through Rapid Start; **# of clients enrolled in RS program after 6 months of a new contracted site reduce # of days to ARVs; reduce # of days to viral suppression**. **(NHSP Indicator# 2, 3, 5)**	eHARS, Provide, CareWare; VDH contracts
Strategy B: Continue implementation of Status Neutral Service Navigation utilizing patient navigators to connect newly diagnosed PWH to care and support services within two weeks. *(Diagnose, Treat, Prevent)*	CDC	Increase the % of clients linked to care within 30 days of diagnosis. **(NHSP Indicator# 1, 2, 3, 5, 6a-h, 7, 8)**	eHARS, Provide
Strategy C: Continue working with HIV Surveillance, LHDs and disease intervention specialists (DIS) to improve linkage rates among PWH diagnosed in the private sector, community-based, or LHD clinics. *(Diagnose, Treat, Prevent)*	CDC	Increase the % of clients linked to care and the % linked to care within 30 days. **(NHSP Indicator# 2, 3, 5)**	eHARS

Strategy D: Continue implementation (and evaluation) of Unified Eligibility for RWHAP B program to reduce client and staff burden and help promote uninterrupted access to care. *(Treat, Prevent)*	HRSA	Increased retention in care, increased viral suppression. **(NHSP Indicator# 2, 3, 5)**	eHARs, Provide, CareWare

Objective 2.2: By December 31, 2026, increase re-engagement and retention in care and adherence to HIV treatment to achieve viral suppression.			
Key Partners: DDP, Ryan White Cross-Parts, CBOs, Medicaid, behavioral health and mental health service providers, housing providers and transportation services, Department of Corrections, local and regional jails			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Continue to improve use Data to Care protocols to identify and re-engage people with HIV into care and other services. *(Treat, Prevent)*	CDC, HRSA	# of PWH re-engaged in care; # of re-engaged PWH who achieve viral suppression; **(NHSP Indicator# 2, 3, 5)**	eHARS, CareMarkers database, Provide
Strategy B: Identify and assess barriers for PWH with evidence of episodic care, high viral load, or other markers for falling out of care and achieve improved health outcomes. *(Treat, Prevent)*	HRSA	# clients engaged with evidenced barriers, increase % of PWH retained in care, increase # of PWH who are virally suppressed. **(NHSP Indicator# 2, 3, 5, 6a-h, 7, 8)**	eHARS, Caremarkers database, Provide, CareWare
Strategy C: Provide education for PWH in the health insurance or medication access programs (i.e. Medicaid, Medicare, ACA Marketplace, direct ADAP) for which they qualify, to maximize access to health care, improve clinical outcomes, and ensure Ryan White serves as the payer of last resort. *(Treat)*	HRSA	Increase in the # or % of PWH who are enrolled in a medication access program (i.e. Medicaid, Medicare, ACA Marketplace, and direct ADAP). **(NHSP Indicator# 2, 3, 5, 6a-h, 7, 8)**	Provide/ DMAS

Strategy D: Expand access and integrate supportive HIV services (housing, mental health, substance use disorder treatment, food bank/home delivered meals, medical transportation etc.) to increase retention in care and achieve optimal health outcomes including viral load suppression. (*Treat)*	HRSA	Increase # of agencies providing supportive HIV services; increase # of clients accessing supportive HIV services; increase in the % of PWH retained in care and virally suppressed. **(NHSP Indicator# 2, 3, 5, 6a-h, 7, 8)**	Provide; VEDSS;
Strategy E: Integrate STI and hepatitis screening for PWH to achieve optimal health outcomes. (*Treat)*	HRSA	increase # of agencies providing STI and hepatitis screening for PWH; increase # of PWH screened for STI and hepatitis **(NHSP Indicator# 5, Quality of Life)**	Provide; VEDSS;

Objective 2.3: By December 31, 2026, expand capacity to provide whole-person care to PWH aged 50+ and long-term survivors			
Key Partners: DDP, clinical providers ADAP Advisory Committee, VACAC, Division of Pharmacy Services , Department of Medical Assistance Services, Department of Aging and Rehabilitative Services, consultants to VDH RWHAP B			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Annually work with the ADAP Advisory Committee to review RWHAP B medication formularies to meet the specific medication needs of PWH aged 50+. *(Treat)*	HRSA	# and type of medications added to the formularies, drug utilization. **(NHSP Indicator# 2, 3, Quality of Life Measure)**	VA MAP and RW formularies and utilization reports
Strategy B: Initiate a partnership with agencies that provide services to the aging population to assess and address the needs of older PWH, including the Virginia Department of Aging and Rehabilitative Services (such as aging services, housing for adults 50+, substance use treatment, and disability and other medical services). (*Treat)*	HRSA	# of services created/expanded that meet the needs of PWH 50+, # of meetings/ communications with agencies, # of collaborations with agencies that provide services to persons 50+. **(NHSP Indicator# 2, 3, Quality of Life Measure)**	Meeting minutes and documents
Strategy C: Collaborate with community advisory groups and program consultants to identify and prioritize best practices to meet the psychosocial and behavioral health needs of older PWH and long-term survivors including	HRSA	Development of programs and services designed to meet the needs of aging PWH. **(NHSP Indicator# 2, 3, 5, 6g, Quality of Life Measure)**	VACAC and CHPG meeting minutes and documents

substance use disorder treatment, mental health services and programs designed to decrease social isolation. *(Treat)*			

NHAS GOAL #3: Reduce HIV-Related Disparities and Health Inequities			
Objective 3.1: By December 31, 2026, reduce disparities in new HIV infections, in knowledge of status, and along the HIV care continuum			
Key Partners: DDP, LHD, Pharmacies, Clinical sites, CBOs, FQHCs			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Increase enrollment in PrEP services among Black and Hispanic MSM, Black women, and transgender women and GNC individuals through stigma reduction *(Diagnose, Prevent)*	CDC, state	Increase the # and proportion of PrEP enrollments among Black and Hispanic MSM, Black women, transgender women and NCG individuals. **(NHSP Indicator# 1, 2, 3, 6a-h, 7)**	Provide
Strategy B: Prepare written communication, including web content, for the public and providers in plain language at appropriate reading levels to help ensure health and medication literacy. Provide culturally and linguistically appropriate trans creation of materials. *(Diagnose, Treat, Prevent)*	CDC, HRSA	Percentage of client and provider materials written at an appropriate reading level. # of materials translated. **(NHSP Indicator# 2, 3, 7)**	DDP materials checklist
Strategy C: Increase linkage, retention in care, and viral suppression among people with HIV who inject drugs through provider education on substance use disorder-related stigma, use of appropriate person-first language, and increased engagement with CHR and behavioral health providers. *(Treat, Prevent)*	CDC, HRSA	Increase retention and viral suppression rates; # of agencies and staff who receive training in non-stigmatizing service delivery for PWID. **(NHSP Indicator# 2, 3, 5, 6g, 7)**	eHARS, Caremarkers database

Strategy D: Reduce late diagnoses among, and develop strategies to increase linkage to care, for people 55 and older who are diagnosed with HIV. *(Diagnose, Treat, Prevent)*	CDC/HRSA	Increase in testing, increase in linkage to care, decrease in late diagnoses. **(NHSP Indicator# 2, 3, 5, Quality of Life Measure)**	eHARS, Caremarkers database
Strategy E: Expand equitable access to HIV treatment through use of telehealth mobile health strategies, in-home care, or other mechanisms in rural areas and for those with transportation challenges. *(Treat, Prevent)*	HRSA	Increased retention in care; increased viral suppression. **(NHSP Indicator# 2, 3, 5)**	eHARS, Caremarkers database, Provide
Strategy F: Conduct needs assessments through focus groups or other engagement activities for at least two priority populations annually. (*Diagnose, Treat, Prevent, Respond)*	CDC/HRSA	Identification of emerging needs to be addressed through the integrated plan. **(NHSP Indicator# 1, 2, 3, 5)**	focus group notes, survey results,

Objective 3.2: By December 31, 2026, provide public leadership opportunities for people with or who experience risk for HIV infection as well as promote a diverse HIV workforce that is representative of and responsive to the needs of the populations served.			
Key Partners: DDP, clinical sites, CBOs			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Maintain leadership opportunities for PWH and those who experience risk for HIV infection such as Ryland Roane Fellowship Program, Virginia Consumer Advisory Committee, Virginia Community HIV Planning Group, Mind, Body, Soul Advisory Committee, ADAP Advisory Committee, BLOC training, sub-recipient community advisory boards and Part A Planning Councils. *(Diagnose, Treat, Prevent, Respond)*	CDC/HRSA	# and demographics of people who participate on planning bodies and in engagement activities. **(NHSP Indicator# 7, Quality of Life Measure)**	Membership demographics, meeting attendance, individual and cohort trainings supported
Strategy B: Continue participation on the VDH Office of Epidemiology Equity, Inclusion and Action Council and collaborate with the Office of Epidemiology's Health Equity Coordinator to support a diverse workforce. Identify and promote opportunities to reduce health disparities and to improve understanding of	State	# of learning opportunities; # of participants: # of policies developed and implemented to promote health equity and support a diverse workforce. **(NHSP Indicator# 7)**	Meeting minutes, training records, new policies

race, sexual orientation, gender identity, culture, immigration status, mental health and substance use on public health policies and programs. *(Diagnose, Treat, Prevent, Respond)*			
Strategy C: Develop orientation resources for all DDP staff, regardless of role, that address racism, sexual orientation and gender identity, violence, trauma informed approaches, medical mistrust, and person-first language. *(Diagnose, Treat, Prevent, Respond)*	State	# of staff who complete course work by the end of their first year of employment. **(NHSP Indicator# 7)**	Training records, training plans
Strategy D: Provide or ensure that contracted organizations provide training for staff on racism, sexual orientation and gender identity, violence, trauma informed approaches, medical mistrust, and person-first language. *(Diagnose, Treat, Prevent, Respond)*	CDC, HRSA	# of staff at contract agencies that complete training. **(NHSP Indicator# 7)**	Training records, quarterly reports
Strategy E: By December 31, 2023, implement part of VDH's Trauma Informed Care strategic plan by providing a training series in trauma informed approaches that will be implemented for external HIV service providers to help eliminate institutional barriers and implement policies that will contribute to beneficial client experiences and improved health outcomes for both people with risk factors for HIV and people with HIV. (*Treat, Prevent)*	CDC, HRSA	# of agencies and staff that complete training; number of agencies that make structural or policy changes to support improved health outcomes. **(NHSP Indicator# 1, 2, 3, 7)**	Training documents, sub-recipient reports, eHARS, CareMarkers database, Provide

Objective 3.3: By December 31, 2026, address social and structural determinants of health and co-occurring conditions that impede access to HIV services and exacerbate HIV-related disparities			
Key Partners: DDP, Ryan White Cross-Parts, CBOs, other clinical partners			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Collaborate with RWHAP cross parts jurisdictions, and other entities to reduce administrative burdens for clients to access quality HIV care and treatment. *(Treat, Prevent)*	HRSA,	Increased retention in care, increased viral suppression. **(NHSP Indicator# 2, 3, 5)**	eHARs, Provide, CareWare
Strategy B: Assist PWH or those who experience risk for HIV infection with obtaining health insurance to optimize health outcomes and access to HIV treatment, testing, PrEP and behavioral health services. *(Diagnose, Treat, Prevent)*	CDC/HRSA	Increased enrollment in health insurance. **(NHSP Indicator# 1, 2, 3, 5, Quality of Life Measure)**	Provide, contractor quarterly reports, insurance enrollment vendor data and reports
Strategy C: Improving data collection, reporting, and use of VDH HIV, STI, and Viral hepatitis data to inform services for Transgender and non-binary/gender non-conforming persons. (*Treat, Prevent, Diagnose)*	CDC/HRSA	# of data sources that include data collection categories for transgender and non-binary/gender non-conforming persons; # of data presented on HIV, STI, and Viral hepatitis that include transgender and non-binary/gender non-conforming persons. **(NHSP Indicator# 6a, b, c, f)**	Provide, eHARs, CAREWare, EvaluationWeb

NHAS GOAL #4: Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic among All Partners and Interested Parties			
Objective 4.1: By December 31, 2026, coordinate with public and private partners, community-based organizations and academic partners, to address the syndemic of HIV, STIs, viral hepatitis, and substance use and mental health disorders.			
Key Partners: DDP, LHDs, other clinical providers, free clinics, FQHCs, DBHDS, Division of Pharmacy Services			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Strengthen relationships with community service providers (e.g., Community Services Boards, HOPWA and other housing providers, Department for Aging and Rehabilitative Services, DBDHS) to learn about service provision and areas of collaboration. (*Treat, Prevent)*	CDC, HRSA, state	# of organizations, # of areas of collaboration identified, # of meetings with community service providers. **(NHSP Indicator# 5, 8)**	Meeting minutes and documents
Strategy B: Secure additional funding to expand the Naloxone Partners program to ensure access to opioid reversal drugs by people who use opioids. (*Treat, Prevent)*	state, ARPA, DBHDS	# Naloxone kits dispensed # reported overdose reversals. **(NHSP Indicator# 6g)**	DPS prescription data; REDCap
Strategy C: Coordinate services among community based test sites to ensure a strong treatment referral network for people diagnosed with STIs (*Diagnose, Treat, Prevent)*	CDC, HRSA, state	# of people diagnosed in community settings who are linked to STI treatment services. **(NHSP Indicator# 1, 2, 3, 5)**	eHARS
Strategy D: Coordinate services among community based test sites to ensure a strong treatment referral network for people diagnosed with hepatitis C (*Diagnose, Treat, Prevent)*	CDC, HRSA, state	# of people diagnosed in community settings who are linked to hepatitis treatment services. **(NHSP Indicator# 1, 2, 3, 5)**	VEDSS
Strategy E: Coordinate services among clinical providers including LHD, to ensure a strong treatment referral network for people diagnosed with STIs (*Diagnose, Treat, Prevent)*	CDC, HRSA, state	# of people diagnosed in clinical settings who are linked to STI treatment services. **(NHSP Indicator# 1, 2, 3, 5)**	eHARS
Strategy F: Coordinate services among clinical providers including LHDs, to ensure a strong treatment referral network for people diagnosed with hepatitis (*Diagnose, Treat, Prevent)*	CDC, HRSA, state	# of people diagnosed in clinical settings who are linked to hepatitis treatment services.**(NHSP Indicator# 1, 2, 3, 5)**	VEDSS

Strategy G: By December 31, 2024, initiate pilot sites for implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT). (*Treat, Prevent)*	CDC, state, DBHDS?	# of sites funded, # clients screened, # of referrals. **(NHSP Indicator# 1, 2, 3, 5)**	Meeting minutes and documents

Objective 4.2: By December 31, 2026, increase coordination of HIV programs across governmental agencies and with public and private health care payers, community-based organizations, and academic partners			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Work with federal partners (e.g., HRSA, SAMHSA, CDC, HUD) to identify and reduce duplicative reporting, administrative burden, and barriers to seamless service delivery across the care continuum. Identify and implement best practices for working across federal funding streams to ensure optimal outcomes for PWH and those who experience risk for HIV infection. (*Treat, Prevent, Diagnose)*	CDC, HRSA, State	# and types of best practices identified to streamline the HIV service delivery system, # of federal partners engaged. **(NHSP Indicator# 5, Quality of Life Measure)**	Meeting minutes and program documents
Strategy B: Continue the Washington, D.C., Maryland and Virginia partnership to coordinate data exchanges and services across jurisdictions. *(Treat, Prevent, Diagnose)*	CDC, HRSA	# of meetings; # of data exchanges. **(NHSP Indicator# 2, 3, 5)**	Meeting minutes and program documents
Strategy C: Create partnership with other border states (e.g., North Carolina, West Virginia, Kentucky, and Tennessee) to coordinate data exchanges and services across borders. *(Treat, Prevent, Diagnose)*	CDC, HRSA	# of meetings; # of data exchanges. **(NHSP Indicator# 2, 3, 5)**	Meeting minutes and program documents

Objective 4.3: By December 31, 2026, enhance the quality, accessibility, sharing, and uses of data, including HIV prevention and care to measure, monitor, evaluate, and use the information to report progress and course correct as needed in order to achieve the goals of the integrated plan.			
Key Partners: DDP, VDH, DMAS, DBHDS, Veterans Administration, VDOC, VDSS			
Strategies	**Funding Sources**	**Outcomes**	**Data Indicators**
Strategy A: Continue DDP monthly rapid response meetings with participation from STD Prevention and Surveillance, HIV Surveillance, HIV Care Services and HIV and hepatitis Prevention to quickly identify geographic areas or potential areas of concern and intervene in potential outbreaks. *(Respond)*	CDC, HRSA, state	Monthly reports to identify unusual or increased case reporting. Identification of actions needed to prepare for or intervene in potential outbreaks. **(NHSP Indicator# 1, 2, 3, 5)**	Meeting minutes
Strategy B: Identify and engage with key VDH offices (e.g., Health Equity, Community Health Services, Family Health Services, etc.) to promote information sharing and education on services provided to intersecting populations. (*Treat, Prevent, Diagnose*)	CDC, HRSA, state	# of meetings, # of key VDH offices engaged. **(NHSP Indicator 2, 3, 5)**	Meeting minutes
Strategy C: Contribute to development of the VDH electronic medical record to meet health care needs of programs serving PWH and those with risk factors for HIV, STIs and viral hepatitis. (*Treat, Prevent, Diagnose)*	ARPA	Establishment of EMR that meets the needs of HIV, STI and viral hepatitis programs. **(NHSP Indicator# 1, 2, 3, 5)**	Program Documents
Strategy D: Provide annual updates on the Cluster Detection and Response Program to key informants and stakeholder groups including care and prevention providers, the CHPG, and the VACAC. (*Respond)*	CDC	# of presentations conducted each year. **(NHSP Indicator# 2, 3)**	Meeting minutes